



# VineLine

Paratransit Services  
(Rider to Complete)

City of Lodi Transit  
221 West Pine Street  
Lodi, CA 95240  
(209) 333-6706

## ADA PARATRANSIT RIDER CERTIFICATION APPLICATION

The information obtained in this certification process will be used only by the transit agencies in San Joaquin County for the provision of transportation services and will not be provided to any other person or agency without prior written approval of the applicant.

☐ New Application    or    ☐ Recertification

**Please check the transit agency you are applying for (you may select more than one):**

- ☐ Lodi VineLine   ☐ Tracer Transit   ☐ Manteca Transit   ☐ City of Escalon  
☐ For service within City of Stockton and/or unincorporated areas of San Joaquin County, your application will be forwarded to San Joaquin Regional Transit District.

## APPLICANT INFORMATION (Please print or type)

Name \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cross St. \_\_\_\_\_

\_\_\_\_\_  
Mailing Address, if different than above

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Male ☐ Female ☐

Last four digits of your Social Security Number \_\_\_\_\_

Please provide the name and phone number of a LOCAL friend or relative to contact in the event of an emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

1. Do you use any of the following aids for mobility? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter     | <input type="checkbox"/> Cane                |
| <input type="checkbox"/> Crutches          | <input type="checkbox"/> Walker              |
| <input type="checkbox"/> Oxygen Tank       | <input type="checkbox"/> Service Animal      |
| Other _____                                | None   |

**Please Note:** A wheelchair or other mobility device must meet the definition of a "common wheelchair" as specified in the ADA regulations, i.e., "not more than 30" wide and 48" long when measured 2" above the floor, and must weigh less than 600 pounds when occupied".

2. Is your mobility device oversized? ☐ Yes ☐ No

a. If yes, please explain: \_\_\_\_\_

b. Does your mobility device weigh less than 600 pounds when occupied?

☐ Yes ☐ No

3. Is your condition temporary? ☐ Yes ☐ No

If yes, expected duration: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Does your condition change from time to time due to medications, medical treatments, other? ☐ Yes ☐ No

If yes, please explain

\_\_\_\_\_  
\_\_\_\_\_

### **Type of disability:**

5. I have a ☐ **Visual** ☐ **Physical** ☐ **Mental** Impairment

6. **What** is your disability and **how** does it make it **impossible** for you to use the fixed route service?

\_\_\_\_\_  
\_\_\_\_\_

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7. How far can you continuously walk **OR** advance your manual wheelchair without the help of another person? (i.e., number of blocks) \_\_\_\_\_

Could you travel further if you stopped to rest?

☐ Yes      ☐ No      ☐ Sometimes

(If No or Sometimes, please explain why)

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8. Have you ever used any of these transit services? Check all that apply:

☐ Fixed Route   ☐ Paratransit   ☐ RTD Hopper   ☐ Other \_\_\_\_\_

9. How many blocks from your residence is the nearest accessible bus stop?

☐ Less than 1 Block   ☐ 2 to 4 Blocks   ☐ 4 or more   ☐ Don't know

10. Can you independently get on and off a lift-equipped bus?

☐ Yes      ☐ No      ☐ Sometimes      ☐ Don't know

(If No or Sometimes, please explain why)

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11. Would your ability to use public transit affected by weather or environmental/architectural barriers that block your path of travel? (e.g. temperature extremes, no sidewalks, lack of signal lights at a busy intersection, etc.)

☐ Yes   ☐ No   (If Yes, please explain why)

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12. Can you ask for, understand, and follow directions?

☐ Yes      ☐ No      ☐ Sometimes

(If No or Sometimes, please explain why)

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13. Can you cross a busy intersection?

☐ Yes      ☐ No      ☐ Sometimes

(If No or Sometimes, please explain why)

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14. If you are approved for Paratransit Services will you require a personal care attendant?

☐ Yes      ☐ No

### **Certification of Applicant**

I hereby certify that, to the best of my knowledge, the information I have given in this application is correct and the application will be returned if it is not complete.

I understand that the results of the review will be based on my ability to use the fixed route system. Verification of my disability by my physician or health care professional, identified below, does not guarantee my eligibility for ADA certification of paratransit service.

**Signature of Applicant** \_\_\_\_\_

**Date**\_\_\_\_\_

*If someone other than the applicant completed this application, the following information must be provided.*

Name of person completing the application \_\_\_\_\_

Relation to the applicant \_\_\_\_\_

Daytime phone # \_\_\_\_\_